Anti Wrinkle Injections/Dermal Fillers Consent Form

Client Ref No.	
Aesthetic Therapist	Prasanta
Prescriber	Prasanta Banerjee

Client Name: ___ ____ D.O.B____ _____ Gender:_Female_____

Address: _____

Post code: _____Email_____

Home tel number: _____Mobile: _____

Have you had this treatment before? _____

Please tick what treatment you are having:

Botulinum Toxin (Botox)	X	Dermal Fillers		Other	

HEALTH QUESTIONNAIRE **Please circle the appropriate box**

A	Are you pregnant / breastfeeding?		NO
B	Have you undergone any medical procedure in the past 4 weeks?		NO
	Have you undergone any surgical procedure in the past 6 weeks?		NO
C	Do you ***bruise*** easily?		NO
	Do you suffer from needle phobia?		NO
	Do you have history of / tendency to ***faint*** ?		NO
	Do you have any tendency to keloid of excessive scarring?		NO
D	Have you ever tested positive for HIV or Hepatitis B / C?		NO
	Have you ever been diagnosed of any of the following: Angina, Diabetes, Epilepsy, Hepatitis A, Rheumatoid Arthritis		NO
	Have you ever been diagnosed of multiple sclerosis (MS), Bells Palsy or any other neuromuscular degenerative disorder?		NO
	Have you been diagnosed with any severe mental condition requiring medication and/or hospital admission?		NO
E	Have you had *abnormal reaction* to any procedure before?		NO
	Do you have tendency to develop ***cold sores***, or had one in the past 2 weeks		NO
	Do you have history of ***anaphylaxis*** (severe allergic reaction)		NO
	Do you have history of allergy to any medicines / food / drink		NO
	Have you ever had abnormal reaction to local anaesthetic (injection / cream)?		NO
	Are you taking HRT, steroids or 'blood-thinners (anticoagulants, e.g. warfarin)?		NO
	Have you taken any antibiotics in the past week ? (esp. Gentamicin, Amikacin, Neomycin, Netilmicin(Netromycin) or Tobramycin)		NO
F	**In the area to be treated:**		
	Have you received any aesthetic treatment (e.g. fillers in the past 2 weeks?		NO
	Do you suffer from active skin condition: eczema, acne, psoriasis or cancer?		NO
	Do you have any permanent implants?		NO

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DECLARATION BY THE FACE TO FACE PRESCRIBER.

I am a trained nurse prescriber, and am insured to prescribe botox and dermal fillers and carry out face to face consultations to enable the beauty therapist to carry out the procedure.
I have explained the intended benefits of the treatment to the client along with its limitations and any possible risks. I have carried out a medical examination/questionnaire and discussed treatment alternatives, including 'not having the treatment'. I have afforded ample opportunity to the patient to read and understand the written information provided, which also includes post-treatment advice.
I have discussed with the client in detail about what the procedure involves, and explained that the client may withdraw consent to treatment at any time.

Name _____Signature _____Date_____

Position _____

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DECLARATION BY THE CLIENT RECEIVING TREATMENT

I have received sufficient information about the aesthetic treatment I am to receive from my Beauty Therapist and been fully informed about the procedure I am to undergo. I fully understand the aims and objectives of the treatment. I am aware of the limitations, possible risks and unexpected side-effects that may not be possibly anticipated beforehand; as well as the intended benefit to my appearance and well-being. I also understand the possible risks expected outcome of the treatment, such as an eye droop, has been explained to me.
I have had further opportunity to be consulted by a medically qualified professional and have all my questions answered to my entire satisfaction.
Having considered all aspects, I have decided to have this treatment of my own accord at my risk. I understand that I will not be able to take legal action against my therapist in case of any complications or be entitled to a refund if I am not happy with my procedure.
I agree to follow the post-treatment advice provided.

I further consent to be photographed before, during and after treatment. I understand that these photographs would remain the property of the professional practice and will not be used for marketing purpose without my explicit prior permission.

I understand my right to withdraw consent at any time.

I have had a chance to review the result post treatment and am happy with the procedure carried out.

Name _____Signature _____ Date _____

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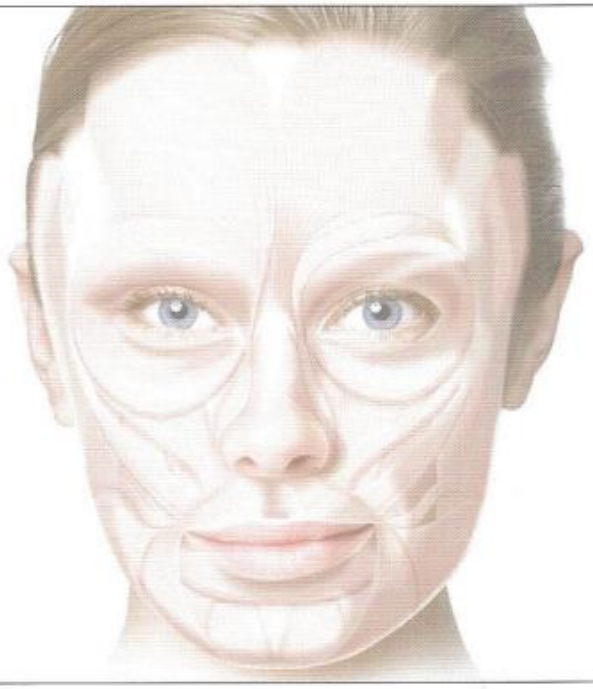
Botox/ Dermal Fillers Treatment Record.

Client Name _____ Aesthetic Therapist_____



Lot number: _____

Date: _____

Notes: _____

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Date: _____

Notes: _____